

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington**

To: Resource Based Relative Value
Scale (RBRVS) Users:
Anesthesiologists
Advanced Registered Nurse
Practitioners
Emergency Physicians
Family Planning Clinics
Federally Qualified Health Centers
Health Departments
Laboratories
Managed Care Plans
Nurse Anesthetists
Ophthalmologists
Physicians
Physician Clinics
Podiatrists
Psychiatrists
Radiologists
Registered Nurse First Assistants

**Memorandum No: 05-59 MAA
Issued: July 1, 2005**

**For Information Call:
1-800-562-6188**

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: Physician-Related Services: Corrections and Fee Schedule Updates

Effective for dates of service on and after July 1, 2005, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2005 relative value units (RVUs);
- The updated Year 2005 Relative Value Guide base anesthesia units (BAUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The updated Medicare Single Drug Pricer (SDP);
- A legislatively appropriated one (1.0) percent vendor rate increase; **AND**
- The technical changes listed in this numbered memorandum.

Below are MAA's July 1, 2005 conversion factors:

| Title | Procedure Codes | July 1, 2005 Conversion Factor |
|------------------------------------|---|---|
| Adult Primary Health Care | 99201-99215 | \$24.82 |
| Anesthesia | | 20.44 |
| Children's Primary Health Care | 99201-99215, 99431-99435, and 99381-99395. | 34.56 |
| Clinical Lab Multiplication Factor | | .820 |
| Maternity | 58611, 59000, 59025, 59400-59410, 59425-59426, 59430, 59510-59525, 59610-59622. | 44.99 |
| All Other Procedures Codes | Except Clinical Laboratory | 22.71 |

Maximum Allowable Fees

MAA has updated the fee schedule with Year 2005 RVUs, BAUs, clinical laboratory fees, and Single Drug Pricer (SDP) pricing. The 2005 Washington State Legislature appropriated a one (1.0) percent vendor rate increase for the 2006 state fiscal year. The maximum allowable fees have been adjusted to reflect these updates.

Injectable Drug Updates

MAA has updated the maximum allowable fees for those drugs listed in the injectable drug fee schedule. These fees are posted on MAA's website at <http://maa.dshs.wa.gov> (click on Provider Publications/Fee Schedules, then Fee Schedules). All fees have been updated at 106% of the Average Sales Price (ASP) as defined by Medicare. If a Medicare fee is unavailable for a particular drug, MAA will continue to price the drug at 86% of the Average Wholesale Price (AWP).

The following new injections require prior authorization (PA):

| HCPCS Code | Brief Description | July 1, 2005 Maximum Allowable Fee |
|-----------------------|-------------------------------|---|
| Q9955 | Inj perflexane lip, micros ml | \$13.25 |
| Q9956 | Inj octafluoropropane mic,ml | 41.60 |
| Q9957 | Inj perflutren lip micros, ml | 62.13 |

Diagnosis Reminder

MAA requires valid and complete ICD-9-CM diagnosis codes. When billing MAA, use the highest level of specificity (4th or 5th digits when applicable) or the services will be denied.

Bariatric Surgery Policy

MAA covers bariatric surgeries in MAA-approved hospitals for bariatric surgery in accordance with WAC 388-531-1600. **PA is required.** For details on PA, see section I.

After Hours

MAA's policy for after hours is defined as:

- The physician is called to come back to the office after leaving for the day; or
- Services received after regular clinic/office hours.

For example: If a clinic closes at 5 pm and takes a break for dinner and then opens back up from 6 pm-10 pm, these services are not eligible for after hours service codes.



Note: This policy does not include radiologists, pathologists, emergency room physicians or anesthesiologists. After hours CPT codes are not covered for any of these specialties.

Internal Lab Code Pricing

Payment calculation for individual automated laboratory tests is based on the total number of automated multichannel tests performed per day, per patient. Reimbursement for each test is based on Medicare's fees multiplied by MAA's fiscal year laboratory conversion factor.

PET Scan Policy

MAA no longer accepts HCPCS codes for PET scans (except G0330 and G0331).

Providers must bill the appropriate CPT code for PET scans. MAA reimburses only for the following PET scan CPT codes: 78459, 78608, and 78811-78813.

All outpatient PET scans require some form of authorization. For details on PA and EPA see section I.

Radiopharmaceutical diagnostic imaging agents

Effective for dates of service on and after May 1, 2005, MAA pays providers for the following codes for radiopharmaceutical diagnostic imaging agents **without** PA:

| Procedure Code | Brief Description |
|----------------|----------------------------|
| 79101 | Nuclear rx, iv admin |
| 79445 | Nuclear rx, intra-arterial |
| 79905 | Nuclear rx, oral admin |

Contrast Material

MAA has adopted the following HCPCS codes to replace A4643-A4647:

| HCPCS Code | Brief Description | July 1, 2005 Maximum Allowable Fee |
|------------|-------------------------------|------------------------------------|
| Q9945 | LOCM <=149 mg/ml iodine, 1ml | \$0.26 |
| Q9946 | LOCM 150-199mg/ml iodine, 1ml | 1.65 |
| Q9947 | LOCM 200-249mg/ml iodine, 1ml | 1.31 |
| Q9948 | LOCM 250-299mg/ml iodine, 1ml | 0.29 |
| Q9949 | LOCM 300-349mg/ml iodine, 1ml | 0.35 |
| Q9950 | LOCM 350-399mg/ml iodine, 1ml | 0.24 |
| Q9951 | LOCM >= 400 mg/ml iodine, 1ml | A.C. |
| Q9952 | Inj Gad-base MR, contrast, ml | bundled |
| Q9953 | Inj Fe-based MR, contrast, ml | bundled |
| Q9954 | Oral MR contrast, 100 ml | bundled |

MAA does not reimburse Q9952 through Q9954 separately.

Home Services

CPT codes 99341-99350 (Home Services) are only reimbursed in place of service 12 (home).

Therapeutic or Diagnostic Injections

MAA has adopted the appropriate HCPCS codes for therapeutic and diagnostic injections.

Do not bill CPT codes 90780 – 90788 in combination with HCPCS codes G0345 – G0353. MAA does not reimburse providers for CPT code 99211 on the same date of service as drug administration HCPCS codes G0345 – G0349, G0351 – G0353, and CPT codes 90780 – 90788. If billed in combination, MAA will deny the E&M code 99211. However, providers may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable services was provided. If modifier 25 is not utilized, MAA will deny the drug administration code.

Botulism Injections

MAA requires PA on Botulism injections (HCPCS codes J0585 and J0587) for all diagnoses.

Anesthesia Policy Clarification

When a planned vaginal delivery (CPT code 01967) is started and results in a cesarean delivery (CPT code 01968) or a cesarean hysterectomy (CPT code 01969), the services for these anesthesia codes are considered one procedure.

If an anesthesiologist and a Certified Registered Nurse Assistant (CRNA) are both involved in this procedure, they must each bill the above procedure codes utilizing modifier QX (CRNA SVC W/ MD MED DIRECTION) and QY (MEDICALLY DIRECTED CRNA).

If a CRNA is not involved, the anesthesiologist must bill for both procedure codes utilizing modifier (AA).

Trauma Section Updates

The contact for reimbursement questions for trauma services has changed. The correct contact person is:

Larry Linn, Hospital Rates Manager
Medical Assistance Administration
Hospital/Managed Care Rates Section
(360)-725-1834

Cochlear Implants Update

MAA has adopted the following HCPCS codes for replacement parts for cochlear implants: L8615-L8622. Providers must bill the appropriate HCPCS codes for replacement parts for cochlear implants. Replacement parts **do not** require PA.

Do not bill HCPCS code A9900 for replacement parts for cochlear implants or MAA will deny the claim.



Note: MAA does not reimburse providers for repairs or replacements that are covered under the manufacturer's warranty.

Urgent Care Site of Service Clarification

MAA incorrectly listed urgent care sites (place of service 20) under the facility setting (page J.2). Urgent care sites are considered to be non-facility centers as defined by Medicare policy. MAA has moved "urgent care facility" to the "Non-Facility Setting" grid on page J.3.

Multiple procedures performed on the same day

For multiple procedures performed on the same day (i.e., multiple lab or X-ray), providers must bill all procedures on the same claim form utilizing the appropriate modifiers if applicable.

Blepharoplasties

Blepharoplasties require PA, regardless of age.

Low Back Pain and Artificial Disc

MAA does not reimburse for Charni artificial disc (total disc replacement procedure codes 0090T-0098T). These procedures are considered experimental.

Maximum Allowable Fee Correction

CPT code 57425 was inadvertently priced at the wrong conversion factor from July 1, 2004-June 30, 2005. **Effective for dates of service on and after July 1, 2005**, MAA has updated the fee with the correct conversion factor.

| Procedure Code | Brief Description | July 1, 2005 Maximum Allowable Fee |
|----------------|------------------------------|------------------------------------|
| 57425 | Laparoscopy, surg, colpopexy | \$543.68 |

Reminders:

- MAA does not cover adult preventive exams.
- MAA limits preventive exams for clients with developmental disabilities to one per calendar year.
- To report critical care services provided in the outpatient setting for neonates and pediatric patients up through 24 months of age, bill using the appropriate CPT code (99291 or 99292).
- MAA does not cover services and/or devices that are considered experimental.
- MAA continues to follow Medicare's policy to not reimburse emergency room physicians for the following procedure codes: 90780, 90781, G0345, and G0356.
- MAA pays for one new patient visit per client, per provider or group practice.
- To report intensive (non-critical) low birth weight services, use the appropriate CPT code (99298 - 99299).
- MAA does not require PA on meningococcal vaccines (CPT codes 90734 and 90733) or pneumococcal vaccines (CPT code 90732).

Billing Instructions Replacement Pages

Attached are replacement pages i-x, 1-2, A.1-A.4, B.1-B.4, B.7-B.16, C.5-C.6, C.9-C.20, D.1-D.16, E.5-E.22, F.7-F.8, F.15-F.42, G.3-G.10, H.1-H.2, I.1-I.22, J.1-J.2, K.3-K.10, L.1-L.6, M.1-M.6, and N.3-N.12 for MAA's current *Physician-Related Services Billing Instructions*.

How can I get MAA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at <http://hrsa.dshs.wa.gov> (click *the Billing Instructions and Numbered Memorandum* link). These may be downloaded and printed.